Virginia Heartburn & Hernia Institute
Minimally Invasive... Maximum Benefit

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Divya Bansal, MS, PA-C

Post-op Diet Guidelines for Dr. Gillian and Dr. Lee

- Your pending surgery has been reviewed in depth with you by your surgeon. These operations all involve working on the upper stomach, the lower esophagus, and the diaphragm.

- We recommend that you scan the QR code specific to your procedure to see animations and surgical videos created by your surgeons so you or your family can be as comfortable as possible about what is involved in your surgery. Details specific to your procedure are below.

- Most of our patients who have had one of the operations below will spend one night at the hospital and be discharge in the mid-morning after you have been seen by the one of our surgeons.

- We always round on our patients prior to discharge. Usually very early or between cases in the OR on the morning after your procedure.

After your surgery....

- Most patients will all have some variation of midline chest pain and shoulder pain from the stitches we placed in the diaphragm during your repair. It typically fades in 24-48 hrs.

- Most patients will have some mild difficulty with swallowing. Typically, they may have pain, cramps in the chest or hiccups. Some may regurgitate if they swallow to quickly or take too large of a bite. It is normal to swallow air after surgery but because of the swelling from surgery belching may be difficult for a few weeks. This may cause uncomfortable bloating called aerophagia. Taking Gas-X or Simethicone tablets with your meals after surgery can help.

- You are going to either be on full liquids or clear liquids in the hospital after surgery and will be given advice on how to proceed with your diet at home. See the recommendations below. If you have questions call us. Do not waste time looking for answers on the internet.

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- We DO NOT want you to advance your diet rapidly on your own. If you try to advance the consistency of the diet too quickly food/fluid will get stuck. It is not unusual for patients to have an occasional episode of vomiting or regurgitation in the first month after surgery even when they follow our directions closely.

- If you are vomiting frequently, we need to know as soon as possible. The forces generated can damage your repair and you may need to go back to surgery.

- We typically DO NOT reorder all your home medications and supplements in the hospital as pills can be difficult to swallow and therefore, we only order what is necessary. We strongly suggest restarting your non-essential medications a week or two after surgery when you have shown you can tolerate a diet without food sticking.

- Dr. Gillian and Dr. Lee are in private practice. There are NO RESIDENTS/PAs/NPs covering our service. If you have a question during the day, contact the office to talk to our staff or the surgeon who did the procedure. If there is an urgent question at night call our office **703 372 2280** to get the answering service so you can talk to the surgeon on-call. Do not use our email for urgent matters.

- Please **do not take yourself to the ER without talking to one of the surgeons**. Most issues after surgery can be handled with a phone call. Rarely patients will need to be evaluated in the ER after surgery but without our input and direction it can be a very frustrating experience. If you do go to the ER without our guidance we are often not contacted, and ER staff will often order studies you do not need and suggest therapies that are pointless.

Diet progression for Anti-reflux procedures

Hiatal hernia repairs, LINX, Nissen Fundoplication, Toupet Fundoplication, Dor Fundoplication and Watson Fundoplication

Please talk to our staff or the doctors about any concerns you are having. Do not rely on a "Google Search" or "Chat rooms" to provide appropriate solutions.

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POST-OP DAY 1 through First office visit-

We want you to stay with a primarily liquid or full liquid diet. We are more concerned with consistency and keeping you hydrated in the first week. Any non-carbonated beverages, smoothies, soups, yogurt, protein shakes/Ensure are fine. Usually grits/cream of wheat, scrambled eggs, runny mashed potatoes are tolerated after a few days if you are careful and eat slowly. Avoid straws as they force you to suck in extra air and this worsens any bloating. We often refer to the initial diet as the "splat diet". Essentially if it goes "splat" when it hits the floor it is generally safe to eat.

Eat/Drink Slowly. One bite or swallow at a time. Make sure you are comfortable, and the first liquid/food bolus has passed into your stomach before you take a second drink/bite.

Frequent small meals/drinks are usually tolerated better than the typical three big meals at this stage. It is normal to feel full faster for a while. It is normal to loos 5-10 lbs. for some patients.

You may feel a delay/pressure as the liquid/food move down and through the esophagus and the site of the repair.

The sensations are very similar for all the procedures. It does not matter if you had a small or big hiatal repair. It does not matter if you had a LINX or some variation of a "wrap" or fundoplication.

If you had a Heller Myotomy with Dor fundoplication, we recommend that you stay with a primarily liquid diet in the first week as your surgery is different and leaves a very delicate thin layer of tissue in the esophagus that needs longer to heal.

DO NOT advance your diet beyond our recommendations until you are seen in the office. If you start advancing and getting food stuck you will create swelling that will slow your progress. If you start vomiting because you pushed your diet too hard you can rupture our repair and may see return of symptoms or the need to return to the OR.

If it feels like something is stuck do not panic. It is in your swallowing tube not your breathing tube. You will not choke. It will generally pass into the stomach, or you will regurgitate it back up. Small sips of warm fluid may help. Do not take large gulps as it will just come back up.

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Some people feel significant abdominal bloating from swallowed air. This is called aerophagia and will generally fade over a few weeks. Taking Gas-X/Simethicone tablets with your meals can help. This does not require a prescription.

First POST-OP check to 3 weeks-

Now is the time to advance you diet slowly. Generally, most things that you can eat with a fork but do not have to cut with a knife work well. Ground meats, fish, pasta, casseroles, and soft/warm foods are usually tolerated. It is recommended that you avoid hard, dry crunchy foods during this time interval. Avoid sandwiches and foods you hold in your hand as we tend to take a bigger bite than we would if we were using a fork or spoon.

There is still a lot of swelling internally, but it is getting better. Your patience will be rewarded. If you push the diet too aggressively and start getting things stuck the swelling starts to increase and your diet progress slows down or goes backwards.

Second POST-OP check-

We are now usually about a month out from your surgery. At this stage you can start adding bread, sandwiches, rice and foods you cut with a knife. Everyone gets to this point at a different pace and even at this stage you can get food stuck if you eat too quickly or the bite is too big.

Patients can get foods stuck months or years after surgery if they eat faster or with larger bites than their new anatomy can tolerate.

Future issues

Most patients have returned to their baseline eating patterns by 3 months and their preoperative GERD or swallowing issues are under control.

Everyone can have a "bad day" with respect to an upset stomach or swallowing in the future that has nothing to do with your surgery. In some case it is from eating too quickly or with too large of a bite, but no damage is done.

If you feel that old preoperative symptoms of GERD, cough, regurgitations, chest pains or swallowing issues are starting to return or are becoming more frequent/intense, please let

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us know. Do not take these issues to your primary care team or your Gastroenterologist unless you have spoken with us first. We have the expertise with respect to post operative issues after your surgery, they do not.

Hiatal Hernia

Closure of the hole in the diaphragm that allowed the stomach to herniate into the chest.

Done with sutures +/- mesh.

Can be small or very large with most or all of the stomach in the chest.

Typically done with a LINX procedure or some type of fundoplication during the same procedure.

The stitching in the diaphragm will typically cause chest pains and shoulder pain for a few days. NSAIDS like ibuprofen/Motrin will help with this pain.

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LINX Procedure

Done to control reflux.

Hiatal hernia is repaired if present.

A Titanium ring with magnets is placed around the esophagus at the gastro-esophageal junction. It opens and closes as you swallow.

When discharged you should be given the small plastic card to keep that identifies your implant. This card comes from the OR. Let us know if they did not give it to you.

Avoid MRI studies if possible but if required do not get in a machine stronger than 1.5 Tesla. Contact our office if there is any confusion.

Nissen Fundoplication

Done to control reflux.

Used in patients with normal esophageal motility/contraction strength.

Hiatal hernia is repaired if present.

The stomach is wrapped 360° around the gastro-esophageal junction to control reflux.

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Toupet Fundoplication

Done to control reflux.

Used in patients with poor esophageal motility/contraction strength.

Hiatal hernia is repaired if present.

The stomach is wrapped 270° around the gastro-esophageal junction to control reflux.

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Heller Myotomy and Dor Fundoplication

Complex surgery typically done to relieve swallowing problems related to Achalasia.

Patients with Achalasia have an esophagus that does not contract and a lower esophageal sphincter that does not relax.

The muscles on the upper stomach and lower esophagus are cut down to the thin mucosal layer so that the swallowing will be easier. This is the "myotomy."

The esophagus does not start working after surgery, but food will pass easier with gravity into the stomach. This relieves the pre-operative regurgitation symptoms.

A gentle 180° wrap of the stomach over the myotomy is done to protect you from reflux after surgery.

Patients are at risk for a leak from the myotomy as the tissue are paper thin. Sudden chest pains can be a sign of leak and should be relayed to the surgeons.

You may have a tube inserted into your stomach via the nose during the surgery. It is done to protect you from any leaks in the esophagus or stomach after surgery. DO NOT pull this tube out. It is dangerous as the tissues are thin and could tear. It will usually be clamped after surgery unless you have nausea/vomiting after surgery. You may still have clear liquids with the tube in place. Some patients will go for an x-ray study on the morning after surgery and have their tube pulled after the study is seen by the surgeon.

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